THEMBISILE-HANI LOCAL MUNICIPALITY

DRAFT INCAPACITY DUE TO ILL HEALTH POLICY

2024/25

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Table of Contents

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INCAPACITY DUE TO ILL HEALTH / INJURY POLICY

1. PREAMBLE

The Labour Relations Act sets out certain guidelines in handling incapacity. These are the Municipality's policy provisions in dealing with incapacity due to ill health / injury.

2. PURPOSE

The purpose of this policy is to ensure the Municipality's operational efficiency while at the same time ensuring that termination of employment for reasons of incapacity due to ill-health or injury takes place substantively and procedurally fair. Also to manage reasonable accommodation for employees with medical conditions.

3. SCOPE

The policy shall apply to all employees of the Municipality.

4. LEGISLATIVE AND POLICY FRAMEWORK

- Constitution of the Republic of South Africa Act 108 of 1996
- Municipal Systems Act 32 of 2000
- Municipal Structures Act 117 of 1998
- Local Government: Regulations on appointment and conditions of employment of senior managers, dated 17 January 2014
- Local Government: Municipal Staff Regulations, 2016 (issued in terms of Section 72, read with Section 120 of the Municipal Systems Act 32 of 2000)
- Local Government: Guidelines for the Implementation of the Municipal Staff Regulations, 2016 (issued in terms of Section 72, read with Section 120 of the Municipal Systems Act 32 of 2000)
- Labour Relations Act 66 of 1995
- South African Local Government Bargaining Council: Collective Agreements
- Occupational Health and Safety Act 85 of 1993
- Basic Conditions of Employment Act 75 of 1997
- Compensation for Occupational Injuries and Diseases Act 130 of 1993

5. DEFINITIONS

All terminology used in this policy shall bear the same meaning as in the applicable legislation, or as defined and / or explained in the Glossary of the Human Resources Policies Manual.

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6. PROBLEM STATEMENT

The policy is aimed at addressing the issue of incapacity due to ill health to those employees who are not able to perform their appointed duties due to various health conditions or injuries. Employees would be referred to the appointed service provider (at that time) to obtain a medical report that would confirm the existing condition. (permanent or temporary)

7. POLICY PROVISIONS

7.1 General Principles

7.1.1 The Municipality is committed to treating any employee incapacitated due to illness or injury in a fair and appropriate manner to their particular situations.

7.1.2 As such, no employee shall be subjected to any form of victimisation or unfair discrimination as a result of their illness or injury.

7.1.3 The degree of incapacity, as well as the permanency of the incapacity, shall be considered when assessing the person's suitability for continuous employment.

7.1.4 The cause of the incapacity may also be relevant. In the case of incapacity due to substance abuse, such as alcoholism or drug abuse, counselling and rehabilitation may be appropriate steps to be considered.

7.2 Guidelines for Managing Incapacity

7.2.1 Temporary incapacity

7.2.1.1 If an employee is temporarily unable to work, the Municipality shall investigate the extent of the incapacity of the injury or sickness.

7.2.1.2 Such an investigation shall include appropriate medical and occupational diagnosis or prognosis.

7.2.1.3 If the employee is likely to be absent for a time that is unreasonably long in the circumstances, the Municipality shall investigate all the possible alternatives short of dismissal. The employee and his / her representative shall be given an opportunity to state reasons as to why alternatives short of dismissal should be considered.

7.2.1.4 When alternatives are considered, relevant factors might include the nature of the job, the period of absence, the seriousness of the illness or injury and the possibility of securing a temporary replacement for the ill or injured employee.

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7.2.1.1 If the employee's medical report indicates that his / her condition has improved and the employee is capable of performing his / her duties, failure to do so shall lead to disciplinary action being taken.

7.2.2 Permanent incapacity

7.2.2.1 In cases of permanent incapacity, the Municipality shall ascertain the possibility of securing alternative employment, or adapting the duties or work circumstances of the employee to accommodate the disability. This could include an alternative job of a lower rank.

7.2.2.2 In the process of the investigation, the employee shall be allowed the opportunity to state a case in response, and to be assisted by a fellow employee.

7.2.2.3 Particular consideration shall be given to employees who are injured at work or who are incapacitated by work related illness. In these cases the Municipality shall, as compelled by legislation, assist employees to claim compensation for occupational injuries and diseases.

7.2.2.4 Termination of employment shall only be considered if the employee's disability cannot be reasonably accommodated by adapting his / her duties or work circumstances, and an alternative position is not available.

7.2.2.5 Should the employee be unable to continue working, the Municipality shall assist the employee, in terms of the retirement fund rules, to apply for a Permanent Health Insurance (PHI) benefit. The Municipality cannot however be held liable for compensation should the PHI claim not be approved by the insurers. Such application shall be made as soon as it becomes apparent the employee would be unable to continue normal duties.

7.2.2.6 The above investigation shall be conducted by an ad hoc committee that will be established by the municipality.

7.2.2.7 The committee shall assess and evaluate the application for ill health, and submit recommendations to the Municipal Manager for approval and implementation

7.2.2.8 The committee shall comprise of a Chairperson; departmental representatives and two labour movement representatives.

7.2.2.9 After the committee has completed the investigation and issued

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the final verdict, the employee will be referred to the rules and procedures of the relevant pension fund.

7.3 Roles and responsibilities

7.3.1 The Municipal Manager or his / her delegated assignee(s) accept overall responsibility for the implementation and monitoring of the policy.

7.3.2 The financial implications related to implementing this policy shall be qualified and quantified by Human Resource Management in consultation with the Chief Financial Officer.

8. POLICY MONITORING AND EVALUATION

8.1 This policy shall be implemented and effective once recommended by the Local Labour Forum and approved by Council.

8.2 Non-compliance to the stipulations contained in this policy shall be regarded as misconduct, which shall be dealt with in terms of the Code of Conduct.

8.3 Head of Corporate Services shall carry out the monitoring and evaluation of the policy's implementation.

9. POLICY APPROVAL

Formulated by HR Management: Signature: _____ Date: _____

Recommended by Portfolio Committee

on Corporate Services: Signature: _____ Date: _____

Approved by Municipal Manager: Signature: DocuSigned by: 8E47CE96789E4E7 Date: 6/5/2024

Annexture A

THE PROCEDURE TO BE FOLLOWED WHEN APPLYING FOR INCAPACITY DUE TO ILL HEALTH AND LIGHT DUTY

1. The supervisor or line Manager must report to HRM in writing that the employee is no more able to perform his/her duties he is appointed for due to a health condition.
2. The employee must submit a Doctor's report that explains the condition to HRM, Occupational Health and Safety unit.
3. The matter will be referred to the committee for incapacity to check the case and refer it to the service provider.
4. The OHS office will complete the referral form, signed by an employee and the Line Manager or Supervisor.
5. The OHS unit will submit the form to the service provider for Wellness Program for referral
6. The service provider will refer the matter to their Occupational Therapist, then to the specialist who will confirm the condition of the employee.
7. The service provider will issue a final report for permanent or temporary incapacity.
8. The committee for Incapacity process will check the report and communicate the results to the applicant
9. In case of a reasonable accommodation, the report will be directed to HRM and the Department concerned for placement.
10. In case of a permanent incapacity, the matter will be referred to Personnel office for the claiming of benefits.

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ANNEXURE B An application for incapacity due to ill health form, and application for reasonable accommodation

INCAPACITY/DISABILITY /ILL-HEALTH /REASONABLE ACCOMMODATION ASSESSMENT FORM

PART ONE: EMPLOYER'S DECLARATION

1. GENERAL PARTICULARS

Name of Retirement Fund			
Name of Employer/Municipality / Division			
Employee's Surname		First Name	
Date of Birth		ID Number	
Member's Reference Number			
Date joined Company		Date joined Fund	
Monthly Pensionable Salary		Retirement Age	
Physical address of Company / Department			
Contact person in Company / Division		Designation	
Tel Number		Fax Number	
Email Address			

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2. DETAILS OF EMPLOYMENT

Job Title			
Still Working	ρ Yes ρ No	ρ Full Time / ρ Part Time	
On Sick Leave	ρ Yes ρ No	Last day actively at work	
Unpaid Leave	ρ Yes ρ No	Expected date of return	

List the essential and regularly performed work tasks with a brief description of each

Type of work duties	**% of time spent Performing**
Administrative / Clerical / Professional	
Manual / Handling machinery or equipment	
Commercial work (buying / selling)	
Supervision or inspection	
Other duties, please specify	

Work environment	**% of time spent working**
Office or administrative environment	
Factory or industrial environment	
Working outside	
Driving : specify type of vehicle	
Other , please specify	

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Exposure to adverse conditions	Exposed (Yes / No). If Yes, describe
Extreme temperatures	ρ Yes / ρ No
Noise	ρ Yes / ρ No
Dust	ρ Yes / ρ No
Fumes	ρ Yes / ρ No
Heights / Depths	ρ Yes / ρ No
Rough terrain	ρ Yes / ρ No
Other hazards, please specify	ρ Yes / ρ No

Specify machinery, equipment, tools and materials being used :

Physical Demands :

Complete the table below indicating the amount of on-the-job time spent on the following activities each working day :

Activity	Never	Sometimes	Often	Always
Standing				
Walking				
Sitting				
Use of both hands				
Reaching above shoulder height				
Reaching below shoulder height				
Climbing and balancing				
Kneeling and crawling				
Bending				
Lifting and carrying				
Pushing and pulling				
Working in cramped conditions				
Hearing essential				
Visual acuity essential				
Other, please specify				

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Indicate the amount of time spent exerting force to lift, carry, push or pull weights

Force / weight	Never	Sometimes	Often	Always
0 to 5 kg				
5 to 15 kg				
15 to 30 kg				
30 to 50 kg				
More than 50 kg				

Mental Demands :

Indicate how much of the member's job requires the following abilities

Abilities	Never	Sometimes	Often	Always
Verbal communication				
Written communication				
Calculations / figure work				
Concentration				
Memory				
Following instructions				
Giving instructions				
Planning				
Problem solving				
Decision making				
Specialised knowledge				
Other, specify				

Complete the employee's sick leave record for the last 2 years

From	To	Number of working days	Reason

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Describe the specific difficulties the employee has in performing his / her job, with reference to specific duties and environmental factors

Describe any other factors, either at work or outside work, which could be contributing to the employees difficulties in performing his / her work duties satisfactorily

Is it expected that the employee will recover to the extent of returning to work?		ρ Yes ρ No
If Yes, specify below		
Same job		
Adapted		
Alternative job		
Expected date of return		ρ Full Time / ρ Part Time

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Describe any efforts made to accommodate the employee's impairment/s, work challenges or disability by adapting the environment and duties, or by placing the member in an alternative work position

List alternative jobs in the company, together with a brief description, which the employee may be asked to perform in the future

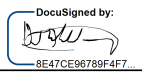
3. DETAILS OF BENEFITS / COMPENSATION FROM OTHER SOURCES AS A RESULT OF DISABILITY (CURRENT OR ANTICIPATED)

Source	Amount	Date of payment	Period of payment

4. DECLARATION

I hereby declare that the employee has been informed of the employer's expectations of him in terms of his/her work performance and that the onus is on him/her to prove incapacity/inability to execute the work that he/she has been employed for and that any consideration by the employer shall be made on the basis of valid medical information /detailed reports from the relevant medical practitioners.

I hereby declare and warrant that the information given above is factual, true and correct, and that no material information has been withheld nor any relevant circumstances omitted.

Signature 

_____ Date 6/5/2024 _____

PLEASE ATTACH THE FOLLOWING:

- Job description
- Sick leave records over the last two years, with copies of sick leave certificates

INCAPACITY/DISABILITY /ILL-HEALTH REASONABLE ACCOMMODATION ASSESSMENT FORM

PART TWO: EMPLOYEE'S DECLARATION

This declaration will be used in the assessment of your request for incapacity/disability /reasonable accommodation assessment. Please ensure that each question is answered fully and accurately.

1. PERSONAL PARTICULARS

Surname		**First Names**	
Date of Birth		**ID Number**	
Employee Reference Number			
Medial Aid Scheme		**Medical Aid Number**	
Residential address			
Postal address			
Office hours contact number		**Home contact number**	
Alternative contact number		**Cellular number**	

2. DETAILS OF EDUCATION AND TRAINING

Please give details of your highest level of schooling, post-school education and training (academic, technical, in-service, etc)

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Year	Institution	Qualification

3. DETAILS OF WORK

Apart from your present job, please supply your work history over the past 10 years

From	To	Company	Position

Current or most recent job	
Company/Organisation / Division	
Current employment status	ρ Full time / ρ Part Time / ρ Sick Leave / ρ Unpaid Leave
Date on which you were last actively able to do this job?	

Please describe your main work duties and functions.

4. DETAILS OF DISANILITY/INCAPACITY AND MEDICAL CARE

Describe the illness / injury that has given rise to this your request to request the employer to consider review of your incapacity/ill-health/disability/reasonable accommodation

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When did you first consult a medical Doctor/Specialist in connection with the above?			
Name of Doctor		**Date**	
Specialty		**Tel No**	
Address			
Details of your usual family / general practitioner			
Name of Doctor		**Tel. No**	
Address			
Date of last consultation			

Please give the names of doctors, specialists, other health professionals and hospitals you have attended in connection with your Incapacity/disability/ill-health

From	To	Doctor / Hospital	Specialty	Address and Tel Number	Treatment / Surgery received

Details of other concurrent or past illnesses / injuries which you feel may have contributed to your disability/Incapacity/Ill-health

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Current treatment and medication (list all medications and dosages)

5. DETAILS OF THE IMPACT OF YOUR HEALTH CONDITION ON YOUR WORK PERFORMANCE

List the work duties which you are able to perform

List the work duties which you are not able to perform

Describe specific difficulties you are experiencing in performing your duties

When will you be able to return to your present job?		ρ Full Time / ρ Part Time
If not able to resume your present job, what alternative jobs could you perform in the Company?		
Detail any alternative jobs (within or outside the Company or in self-employment) you have performed before after became ill / injured		

Detail any other jobs or income producing activities you may be able to perform in future

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6. DETAILS OF IMPACT OF YOUR HEALTH CONDITION ON OTHER FUNCTIONS

Describe the practical implications of your illness/injury on the following activities of daily living:

Mobility (standing, walking, sitting, bending, carrying etc)
Self-care (eating, dressing, bathing etc)
Home management (domestic chores, gardening, shopping, home maintenance, etc)
Transport (driving, use of public transport, etc)
Sport and recreational activities
Other

7. DETAILS OF OTHER INCOME / COMPENSATION

Have you received / are you receiving / do you expect to receive any benefit, salary or income from other sources, such as insurance companies, pension, provident or retirement annuity fund, any state fund, compensation for occupational injuries and diseases, a business venture or any other source?

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Source	Amount	Date of Payment	Expected period of payment

AUTHORISATION AND DECLARATION

Authorisation

I hereby authorise my medical practitioner, the Superintendent of the medical institution, or any other person from whom I have received medical, homeopathic or other treatment, alternatively any department who possesses such medical record to release such medical records and to furnish the said records or copies thereof to the Centre for Occupational and Wellness Services (Health1st). I acknowledge and understand that the medical records may contain certain confidential information regarding both my physical and / or mental health.

I hereby authorise the Centre for Occupational and Wellness Services to furnish any information contained in medical reports or otherwise obtained during the course of the assessment of my application for incapacity/ill-health assessment to any health professional who may require such information to assist the Centre for Occupational and Wellness Services in the assessment of my request for assessment of my incapacity/ill-health.

Declaration

I hereby declare and confirm that the answers given by me or the information disclosed in this form are complete in all respects, are both true and correct (whether in my handwriting or not) and that no material information has been withheld nor has any relevant information regarding my physical and / or mental health been omitted, either intentionally or negligently.

_____ _____

Signature of the claimant **Date**

_____ _____

Witness **Date**

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INCAPACITY/DISABILITY /ILL-HEALTH REASONABLE ACCOMMODATION ASSESSMENT FORM

PART THREE: CONFIDENTIAL MEDICAL REPORT

An application for a disability benefit has been submitted by one of your patients. Your completion of this report is required in order to assist in the assessment of this claim. Please also attach copies of any medical reports or results of investigations to substantiate the medical condition/s of your patient.

Name of patient		**Date of Birth**	
Employer		**Occupation**	

Date of first consultation		**Date of last consultation**	

Height of patient		**Weight of patient**	

Main diagnosis and cause of disablement

Detail the onset and history of the illness / injury

Concurrent conditions

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Please give details of your consultations with the patient over the last 2 years			
Date	**Complaint**	**Treatment**	**Response**

Details of the last clinical evaluation

Detail objective findings, such as blood tests, X-ray reports, ECG's, echocardiographs and histology reports

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Please comment on the nature and extend of any functional impairment related to the illness / injury

Does the patient's work duties and /or environments aggravate the illness or injury ρ Yes, please describe below ρ No

Please provide details of other medial practitioners consulted or of hospital admissions over the past 3 years			
Date	**Medical practitioner / Hospital**	**Speciality**	**Treatment / Surgery**

Please provide details of present treatment, include mediation and dosages, rehabilitation, counseling etc.

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If applicable, please detail any complications or side effects of treatment

Please comment on the patient's response and compliance to current treatment

What further medical treatment, procedures or investigations would you recommend?

What further rehabilitation is envisaged for the patient?

Prognosis

When was the employee/patient last able to perform his / her job?	
If the patient is temporarily unable to perform his /her occupational duties, when do you expect the patient to be able to perform his / her occupational duties?	
Some duties	
All duties	
If the patient is permanently unable to perform his / her occupational duties, please comment on other types of work he / she may be capable of performing	

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Other comments or any additional information which will assist in the assessment of this claim

Signature of medical attendant			
Name (in block letter)			
Date		**Contact No**	
Qualifications / Specialty			
Address			

Approved by Municipal Council on the 23rd of May 2024 and signed by the Municipal Manager

DocuSigned by:
8E47CE96789F4F7...

DJD Mahlangu

6/5/2024

Date